Los Angeles County **Department of Public Social Services**

SUBSTANCE ABUSE RECOVERY PROGRAM
TREATMENT PROVIDER REPORT OF CHANGES

TO: ______________________ Assessment Center FROM: ______________________ Treatment Provider Contact Person: ______________________ Signature ______________________ ____________ Print Name Date	FROM: ______________________ Assessment Center TO: ______________________ DPSS Case Manager/EW Signature ______________________ Print Name ______________________ ____________ File Number Date ______________________ Telephone Number

Participant Information:

Name:	Case Number:
Social Security Number:	Date of Birth:

Section I. (Sections I, II, and III Completed by Treatment Provider/DPH Assessment Centers)

This is to inform you that the above-referenced GR participant:
- Is participating in treatment ______hours per week
- Successfully completed treatment on__________
- Dropped out of treatment on ________________
- Transferred from residential to outpatient treatment on________________
- Transferred from outpatient to residential treatment on________________
- New facility:____
- Participant has a reunification plan with the Department of Children and Family Services
- Other:____

Section II.

This is to request that the above-referenced GR participant be referred to:
- Department of Health Services for a medical evaluation
- District DMH/APS staff for evaluation for possible mental problems
- DPSS' SSI advocate to process an SSI application
- Healthy Way LA
- Grow Appraisal/Orientation
- Other

Section III.

This is to request a three-month extension in treatment services for the above-referenced participant.

Section IV. (Completed by DPSS Case Manager/EW Only)

Request for extension in treatment services for the above-referenced GR participant is:

Approved through________________________ Denied – Reason:_____________________________

______________________ ____________ ______________________
Case Manager/EW Signature Date Telephone Number